State of California Department of Consumer Affairs

ACUPUNCTURE BOARD
1424 HOWE AVENUE, SUITE 37, SACRAMENTO, CA 95825-3233
TELEPHONE: (916) 263-268/ FAX: (916) 263-2654
CA RELAY SERVICE TT/TDD (800) 735-2929 / DCA TDD (916) 322-1700

CONSUMER COMPLAINT FORM

PLEASE PRINT OR TYPE Please provide all the requested information

COMPLAINT REGISTERED AGAINST	
Name of Acupuncturist	AC Use Only License #:
Name of Clinic	
Address	Telephone #:
City/State/Zip	
PERSON REGISTERING COMPLAINT	
Name	Relationship to Patient
Address	Telephone #:
City/State/Zip	
Patient's Name	Date of Birth
Has patient been examined or treated by another acupuncturist or healthcare practitioner for the same complaint? Yes ? No ? If so, please give full name(s) and address(es):	
DETAILS OF COMPLAINT	
Type of Illness/Reason for Appointment:	Date(s) of Visit:
State your complaint in detail (use additional sheets as necessary): _____ _____ _____ _____ _____	

NOTICE: Except for the name of the acupuncturist, all information requested is voluntary, but failure to provide the requested information may delay or prevent the investigation of your complaint. As much information as possible should be provided in connection with the complaint. The information on this form will be used in part to determine whether a violation of State law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies, including the Attorney General's office.

Signature_____ Date_____

ACUPUNCTURE BOARD

AUTHORIZATION FOR RELEASE OF ACUPUNCTURE, MEDICAL, PSYCHIATRIC, ALCOHOL, OR DRUG ABUSE PATIENT RECORDS

Patient Name: _____ Date of Birth:_____

I, the undersigned hereby authorize:

(1) _____ (3)_____

_____ _____

(2) _____ (4)_____

_____ _____

_____ _____

to disclose records in the course of my diagnosis and treatment, to include acupuncture, medical, psychiatric, alcohol and drug abuse to:

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
ACUPUNCTURE BOARD / DIVISION OF INVESTIGATION

This disclosure of records authorized herein is required for official use, including investigation and possible proceedings regarding any violations of the laws of the State of California.

This authorization shall remain valid until the Acupuncture Board of the State of California completes its investigation and proceedings arising out of the investigation.

A copy of this authorization shall be as valid as the original.

Patient Signature_____ Date _____

- OR -

Representative Signature_____ Relationship Patient_____ Date_____

I understand that I have a right to receive a copy of this authorization if requested by me.